questions. As to whether children might be less susceptible than adults to hepatitis, Maj. Laird would have thought the position to be the reverse. It was true to say of epidemic infective hepatitis that it was a disease of children and young adolescents, and if that had any bearing on jaundice in syphilitic children, he would suppose that they were more susceptible to hepatitis than was the adult. In the children's clinic presumably a considerable proportion of the arsenical injections were intramuscular rather than intravenous. It was Dr. Nabarro's clinic and his views that he had had in mind when he said that jaundice was relatively rare in the treatment of children, and for that very reason.

Dr. Teeuwen's observations underlined what Maj. Laird had said about the nomadic patient's additional risk of syringe-transmitted infection. The whole matter of syringe transmission was rather fortuitous. It was possible to use an incompetent syringe technique perfectly satisfactorily, without any jaundice at all, until such time as infection was introduced, and then, if the precautions against its spread were not adequate, the trouble might start. From the records of the civil clinic about which he had spoken he had obtained a curve showing the percentage incidence of jaundice and of arsenical dermatitis for every year from 1918 to 1944. The curve for dermatitis was a fairly steady one and was about 3-6 per cent ; there was almost no year in which dermatitis failed to occur. The jaundice curve was entirely different. There was no case of jaundice in that clinic up to 1924, in which year there were a few isolated cases ; after that it was free of jaundice up to 1932, when there was a very mild outbreak in which he could find no evidence of case-to-case transmission, and which he thought corresponded to a local epidemic of infective hepatitis. In 1939 there were about 6 cases ; in 1940 there was no case ; at the end of 1941 two cases from the Forces came in and jaundice developed after a few injections ; obviously these patients had been infected from outside. From then onwards there was a steady building up of cases in that clinic until sterilization by heat was introduced ; 3 months later jaundice disappeared from the clinic. Therefore one had to bear in mind the conditions which obtained before syringe transmission was introduced ; if that were done it would be easier to understand certain data which appeared to clash with the theory of syringe transmission.

ANNOTATION

THE ONE-MAN CLINIC*

It might be that this contribution to the discussion of the able paper by Dr. Erskine ought to be prefaced by an apology, because, three years ago, when I was appointed as temporary Venereal Diseases Officer to the local clinic, I had few qualifications other than a keen desire to give the best possible service to the patients. As this clinic is on the periphery of the Venereal Diseases Service, some account of my impressions and difficulties may be of interest both to those who are placed in a similar position and to those who are more fortunate and who work in the acknowledged centres and large venereal diseases clinics.

Venereal disease work in a small town presents its own peculiar difficulties, especially when the clinic is held only once a week. The first difficulty which I encountered was that, during the hours of my clinic, all work in a neighbouring aircraft factory appeared to be suspended and the girls there used to watch, from the windows which overlooked the entrance, the patients going in and out of the clinic. This complication necessitated an interview with the ever helpful County Medical Officer, which resulted in a screen being erected to provide privacy for the attending patients. Later, a rise in the production curve of the factory was noted!

At this time I was able to engage as nurse-almoner a lady who was interested in the social aspect of the work. We agreed that in a small town a common waiting room is a form of torture chamber that should not be endured. Several other rooms were used for the people to wait in and, with common sense and care, the present premises became quite adaptable to the purpose of shielding the more sensitive patients, so that they were able to continue their treatment with a reasonable prospect of privacy. As a result of my experience, I would say that without a tactful nurse-almoner and adequate waiting rooms no clinic can work efficiently in a small town.

* The above annotation is a late contribution made by its author to the Discussion following Dr. D. Erskine's paper, " Difficulties in the successful treatment of the venereal disease patient", read on the 27th January 1945, and published in the June 1945 number of the *Journal.*

Bacteriological examinations

The next important difficulty to be overcome was the provision of an efficient bacteriological service for the clinic. Here I have been extremely fortunate, in that I made a point of establishing a close liaison with the County Bacteriologist by letter and by a personal visit, and thus obtained his enthusiastic cooperation, which has provided a continued support to the efficient working of the clinic; such cooperation is another fundamental necessity for the outlying clinics. We worked out the details for the transport of specimens and found that if intelligent use were made of railway passenger services, the matter of transit was not difficult. This route was used also for the transport of specimens for the examination of white blood cells and of blood films for the detection of agranulocytosis. The transport of serum from suspected sores for dark-ground examination was arranged by the use of capillary tubes, which were sealed and sent direct to the laboratory. It seems to me to be absurd for a man who is not a trained pathologist to attempt to make these examinations at the clinic. One examination of a suspected sore is not enough unless it reveals the *Spirochaeta pallida*. If the first result is negative, the patient attends daily for scraping of the sore, and the serum collected is sent in such a way that it reaches the laboratory within a few hours. Here is a service that no doctor attending only one day a week (be he ever so highly skilled a venereologist) could possibly give, but a practitioner resident in the town can repeat this procedure daily until the specialist is satisfied that the sore is non-venereal. In passing, I wonder how many venereologists can diagnose the early stages of agranulocytosis? Personally, I believe that the pathological aspect of these cases is better investigated by a pathologist.

Sterilization of syringes

The next major problem, which I believe to be existing also in some of the larger clinics, is the method of sterilization of syringes. I visited a large clinic in London where I found that syringes were not sterilized efficiently. I experienced considerable opposition to heat sterilization among the staff in my own clinic, on the grounds that there would be a large increase in breakages. Routine boiling of all syringes seems to me to be essential. The breakages are not increased, provided that one uses syringes with glass plungers, the coefficient of expansion of which is the same as that of the barrel; consequently the danger of cracking the syringe by forcing the metal plunger of an ordinary Record syringe into the glass barrel is obviated. If a syringe is washed under the hot tap, it can be replaced in the boiling sterilizer without danger of cracking. Another point is the use of small needles of the type known as Evipan needles. For some women, when a single small vein has to bear the trauma of several courses of injections, these tiny needles are a great help and materially reduce the discomfort of the patient. Another point in technique is the boiling of the specimen glasses which are used for the two samples of urine commonly examined for male patients. I doubt whether these specimen glasses are constructed so as to be boiled, and in my opinion it is absolutely wrong that they should be used for patient after patient, merely being washed out or disinfected in between by some other method than by boiling. Certainly, boiling cracks a large number of these, but they could be made of a better type of glass, assuming that it was known that they were to be boiled. The swabs and towels used in clinics should certainly be autoclaved; I may be quite wrong in believing that this is not generally done.

The clinic and the patient

I cannot but feel that the unspecialized attitude of a general physician is at times a help rather than a hindrance in the management of the general health of those patients who are seen over a great number of months and who, from time to time, complain of symptoms of diseases other than the ones for treatment of which they are primarily attending the clinic. A close liaison between the clinic and the environment of the patient is a help in dealing with the many special

problems which arise during the time that the patient is under treatment, a solution of which materially encourages the patient to continue to feel confident in coming to the clinic for treatment. Here, the efforts of a small clinic can undoubtedly surpass anything that can be done in the way of assistance by the rather more impersonal handling which inevitably characterizes a large venereal diseases clinic.

Deficiencies of a small clinic and suggested remedies

I now come to the other side of the question, namely ways in which the small clinic is likely to be deficient. The most important improvement is that beds should be provided for the treatment of patients attending the clinic whose condition needs in-patient treatment. Without beds no clinic can do really good work, and at the present time the lack of them is the great liability which the small clinic has to face. Every kind of pressure should be put on the authorities concerned to insist that this is a minimum demand and an urgent necessity.

Two other suggestions that I would make are the following. First, that a visiting venereologist of experience and tact should visit outlying clinics and consult with the Medical Officer on points in which the service is falling short. No man who is doing really good work would resent this. It would be an encouragement to him to do better work, and he would be able to consult with the visitor on difficult cases, getting advice and help with such procedures as urethroscopy and other manipulations with which he may be finding difficulty. Secondly, a regular bulletin of procedure and advances in technique could be issued to all clinics. This would ensure that all recent advances would be available to the Medical Officer, who would look forward to its arrival and would be most grateful for the help he would obtain from it. The Ministry of Health has issued such bulletins from time to time, which have been of the greatest help, but their appearance is spasmodic and not nearly comprehensive enough.

Conclusions

I am sure that I speak for many in a similar position to myself, when I say that I have enjoyed my short experience of this work much more than I had anticipated. I feel that there is scope for the highest work to be done in these small clinics by keen men who are interested in social service, and that there is not the slightest need or reason for us to be regarded as backward and awkward members of a great family.

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REVIEWS OF BOOKS

Modern Clinical Syphilology: Diagnosis, Treatment, Case Study. By John H. Stokes, M.D., Herman Beerman, M.D. and Norman Reeh Ingraham (Jun.), M.D. 1,332+7 pp., 911 illustrations and text figures. W. B. Saunders, London, 3rd edition, 1944. Price 50s.

In a review of the second edition of this work, published in 1934 with Stokes as author, I wrote as follows: "The author of this work requires no introduction to European syphilologists. The first edition of the work under review, published in 1926, besides his numerous contributions to the literature have acquired for him a reputation as a determined seeker after truth, with an almost unlimited capacity for taking pains and a great ambition to raise the practice of syphilology to the same high standard of excellence which his own has reached. A study of *Modern Clinical Syphilology* gives one the impression that its author determined to omit nothing that might by any chance be useful to any of his readers in his diagnosis and treatment of any case of syphilis in whatever part of the body the disease happened to be located. Further that his readers should understand the pathological processes at work and the mode of action of the several agencies at his disposal for the cure of the condition." *Mutatis mutandis* in respect of authors, this statement may well be applied to the third edition, the authors of which must be well known to syphilologists in Great Britain; if they were not the modest people we know them to be, they might well have supplied an alternative title of their great work, "Enquire Within Upon Everything Syphilitic".

The space which can be allotted to this review is far too small to enable one to do justice to such an important work, and one must be content with a sketch of its main features and only a very short commentary. The first thirty-three pages deal with the bacteriology and pathology